PHCs and CHCs

1442. SHRIMATI VIPLOVE THAKUR: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) whether Government propose to increase the number of community health centers and primary health centres under the National Rural Health Mission;

(b) if so, the details thereof, State-wise;

(c) the details of funds likely to be provided to these centers, State-wise;

(d) whether it is a fact that doctors are reluctant to work in rural areas; and

(e) if so, the measures taken or proposed to be taken to deal with the situation by Government?

THE MINISTER OF STATE IN THE MINISTRY OF HEALTH AND FAMILY WELFARE (SHRIMATI PANABAKA LAKSHMI): (a) to (c) National Rural Health Mission (NRHM) envisages setting up of Primary Health Centres (PHCs) and Community Health Centres (CHCs) as per 2001 population norms in a phased manner by the State Governments. The requirement of funds for the purpose is to be incorporated by the State Governments in their annual Programme Implementation Plan (PIP) under NRHM. The State-wise shortfalls of PHCs and CHCs as per 2001 population norm is enclosed (*See* below).

(d) and (e) The biggest challenge in the delivery of rural healthcare services is to ensure the availability of services of doctors in PHCs and CHCs.

NRHM envisages provision of one AYUSH Doctor in PHC in addition to a Allopathic Doctor for co-locating AYUSH facilities in PHCs. NRHM also envisages support for upgradation of PHCs and CHCs to Indian Public Health Standards (IPHS). The States are being encouraged to appoint doctors on contractual basis. Multi-skill training of doctors in anesthesia and new born care is being done. A number of States have taken various initiatives to ensure services of doctors in rural areas such as giving cash incentives, difficult area allowance, walk-in interviews for recruitment of doctors etc; Some States have also adopted policy of compulsory rural/difficult area posting for admission to post-graduate courses and as a pre-requisite for promotion, foreign assignment or training abroad; compulsory rotation of doctors etc. The States have also been adopting various Public-Private Partnership models for health care delivery.

Statement

Shortfall in health infrastructure as per 2001 *population in India (As on March,* 2006*)*

		PHCs			CHCs		
Sl. No.	State/UT	R	P	S	R	P	S
1	2	3	4	5	6	7	8
1	Andhra Pradesh	1924	1570	354	481	167	314

1	2	3	4	5	6	7	8
2	Arunachal Pradesh	39	85	*	9	31	
3	Assam	826	610	216	206	100	106
4	Bihar	2489	1641	848	622	70	552
5	Chhattisgarh	659	518	141	164	118	46
6	Goa	22	19	3	5	5	0
7	Guiarat	1172	1072	100	293	273	20
8	Haryana	500	408	92	125	82	43
9	Himachal Pradesh	186	439	*	46	66	*
10	Jammu and Kashmir	271	374	*	67	80	*
11	Jharkhand	806	330	476	201	194	7
12	Karnataka	1211	1679	*	302	254	48
13	Kerala	791	909	*	197	107	90
14	Madhya Pradesh	1670	1192	478	417	229	188
15	Maharashtra	1984	1800	184	496	407	89
16	Manipur	64	72	*	16	16	0
17	Meghalava	90	101	*	22	25	*
18	Mizoram	22	57	*	5	9	*
19	Nagaland	80	84	*	20	21	*
20	Orissa	1171	1279	*	292	231	61
21	Punjab	536	484	52	134	126	8
22	Rajasthan	1555	1713	*	388	325	63
23	Sikkim	17	24	*	4	4	0
24	Tamil Nadu	1173	1252	*	293	165	1.28
25	Tripura	104	73	31	26	10	16
26	Uttaranchal	214	222	*	53	49	4
27	Uttar Pradesh	4390	3660	730	1097	386	711
28	West Bengal	1993	922	1071	498	346	152
29	Andaman and Nicobar Islands	8	20	*	2	4	*
30	Chandigarh	3	0	3	0	1	*
31	Dadra and Nagar Haveli	7	6	1	1	1	0
32	Daman and Diu	3	3	0	0	1	*
33	Delhi	31	8	23	7	0	7
34	Lakshadweep	1	4	*	0	3	*
35	Pondicherry	10	39	*	2	4	*
	INDIA:	26022	22669	4803	6491	3910	2653

Note: The requirement is calculated on the basis of final total and tribal population of Census 2001 in rural areas using the prescribed norms. All India shortfall is derived by adding State-wise figures of shortfall ignoring the existing surplus in some of the States.

R: Required; P: In Position; S: Shortfall; *: Surplus